TO: John DeLuca, Manager for Behavioral Health Quality, MBHP

FROM: Greg Chalmers, Manager, Quality Performance

CC: Wayne Stelk, VP, Quality Management

DATE: March 14, 2002

RE: Listing of 'Homeless' Initiatives

Below is a listing of the various 'homeless' initiatives that the Partnership has managed to this date:

FY 1999

Homelessness

The Contractor shall collaborate with the homeless advocate community to identify strategies and resources to facilitate appropriate psychiatric discharge dispositions for homeless adults who are enrolled in MassHealth Standard in the Persons with Disabilities rating category, MassHealth Basic, and / or DMH Consumers. Following the identification of such strategies and resources, the Contractor will both educate certain mental health inpatient Network providers, primarily in the Boston, and Greater Boston areas, and develop a mechanism to monitor their performance relative to the identified strategies. The compliance target for this standard shall be the submission of a final compliance report evidencing that by June 30, 1999 strategies and resources were identified, providers were educated, and a performance tracking mechanism was developed.

FY 2000

Homeless-Discharge Planning

The Contractor shall continue to collaborate with the homeless advocacy community to identify strategies and resources to facilitate appropriate discharge dispositions for homeless adults (MassHealth Standard/Disabilities, MassHealth Basic, DMH Consumers). The Contractor will also educate certain inpatient mental health providers in the Worcester and Springfield areas on the importance of comprehensive discharge planning for members who are homeless upon discharge. The Contractor shall utilize established tracking mechanisms to monitor performance relative to the identified strategies, and take appropriate network management action with respect to those inpatient mental health providers whose discharge planning performance fails to comply with the Contractor's discharge planning protocol. The compliance target for this standard shall be the submission of a final compliance report evidencing that by June 30, 2000 strategies and resources were identified, providers were educated and the developed performance tracking mechanisms were implemented.

Internet Technology and Resources for Services to Homeless Members

The Contractor shall collaborate with the homeless advocacy and health care provider community to develop and construct a discrete web site that will contain aftercare planning best practices, including referral information for both behavioral health and physical health resources, specifically for providers of services to homeless members. Such information shall be organized regionally, as well as by type of resource. The compliance targets for this standard shall be the development and construction of a discrete web site, the compilation of information on aftercare planning best practices, including referral information for both behavioral health and physical health resources specifically for providers of services to homeless members, and the availability of the information on the web site.

Homeless Shelters and Detoxification Facilities

The Contractor shall work with certain homeless shelters and Network inpatient detoxification facilities on the completion of the Medical Benefit Request in a manner consistent with the process agreed to by the Contractor and the Division.

FY 2001

Benefit Advocacy

The Contractor shall work with certain homeless shelters and certain Network inpatient detoxification facilities on the completion of the Medical Benefit Request in a manner consistent with the process agreed to by the Contractor and the Division.

FY 2002

Improving Behavioral Health Services for Homeless Individuals and Families

A. Strengthening Discharge Planning Protocols for Certain Hospitals Serving Homeless Individuals and Individuals at Risk of Being Homeless

With the goal of promoting exemplary discharge planning practices for homeless individuals and individuals at risk of being homeless, the Contractor shall identify regionally-based hospitals serving a high number of homeless individuals for the purpose of supporting their efforts to facilitate dispositions to supported housing and other community-based resources. The Contractor shall collaborate with the DMH Homeless Outreach Team staff in discharge planning for these individuals at the selected sites.

The compliance target for this performance incentive shall be:

1. Establishing criteria for the identification of individuals who are homeless and those at risk of being homeless;
2. Identifying regionally-based hospitals serving a high number of individuals who are homeless and at risk of being homeless;
3. Obtaining agreements with identified hospitals to participate in this initiative;
3. Collaborating with selected facilities and key stakeholders, and drawing upon the findings of the FY2001 Performance Standard on Discharge Planning and Community Tenure, to establish revised criteria for exemplary discharge planning practices for individuals who are homeless and those who are at risk of being homeless;
5. Increasing utilization of Program for Assertive Community Treatment and Homeless Outreach Teams for the identified population at the identified facilities; and
6. Recommending methods of evaluation of the effects of this initiative on individuals who are homeless and those at risk of being homeless.

B. Families Outreach and Referral ("F.O.R. Families") Homeless Initiative

The Contractor shall collaborate with the Department of Public Health and the Division to increase access to behavioral health services for families living in hotels/motels funded through Department of Transitional Assistance. The goal of this performance initiative shall be the implementation of the "F.O.R. Families" Homeless Initiative in at least of two of the Contractor's five regions, involving at least six hotels/motels where MassHealth Families have been temporarily placed.

The compliance target for this performance incentive shall be:

1. Linking each of the selected hotels/motels with local mental health services, including identification of a provider point-person to serve as a liaison;
2. Establishing links to therapeutic daycare for children not enrolled in daycare;
3. Establishing, as needed, a behavioral health presence in each of the selected hotels/motels (for crisis assessment, treatment, and treatment readiness groups);
4. Producing and distributing to participating families and agency staff information about local behavioral health referral resources;
5. Providing coordination with other behavioral health care services;
6. Collaborating with DPH Regional Coordinators and Home Visitors, and Contractor Regional Staff, to identify and remove barriers to services; and
7. The Contractor's participation on Local Action Teams (the Division, and the Departments of Mental Health, Mental Retardation, Transitional Assistance, Public Health and Social Services).

Network Alert

The Partnership 150 Federal Street, 3rd Floor Boston, MA 02110 800-495-0086 Fax: 617-790-4133

ALERT # 41 JUNE 29, 1999

DISCHARGE PLANNING FOR HOMELESS ADULTS IN INPATIENT HOSPITALS IN REGIONS 1 AND 5

THE FOLLOWING INFORMATION SHOULD BE NOTED AND COMMUNICATED IMMEDIATELY TO YOUR PROGRAM DIRECTORS AND DISCHARGE PLANNERS

This alert serves to emphasize major themes presented in the Partnership-sponsored training, "Discharge Planning For Homeless Adults" held on April 16th, 1999. The training curriculum was the result of months of collaboration between The Partnership and homeless advocates. This alert reiterates that The Partnership discourages the discharge of homeless members to shelters, and that The Partnership offers information regarding discharge planning resources. In addition, this alert reminds inpatient providers of the new Admission, Concurrent Review, and Discharge Review questions which are asked for all the Partnerships' homeless members in inpatient settings.

BACKGROUND

Through collaboration with key stakeholders and advocates, the Partnership has identified discharge planning resources available for homeless adults. Information regarding these resources and access to them was presented to select inpatient providers in the Boston and Greater Boston Regions in a training hosted by The Partnership and Massachusetts Housing and Shelter Alliance (MHSA) on April 16, 1999.

The training featured a panel of Homeless Advocates and Consumers who presented the unique psychosocial needs of the homeless. Presenters stressed the critical need for consumer involvement in treatment and discharge planning. Expert speakers presented a number of discharge planning options which are available to the homeless. A listing of these resources is attached to this alert. The resources listed should be viewed as a “starting point” for discharge planning. The Partnership expects that inpatient providers will explore other resources when planning discharges for homeless members.

RESOURCES

Department of Mental Health: Homeless Outreach Team (H.O.T.)
Homeless Recipients in the cities of Boston, Cambridge, and Somerville may be eligible to receive services through the Homeless Outreach Team (HOT). HOT assists homeless persons to find temporary and transitional housing. Additional services include case management, and outreach services to hospitalized individuals when appropriate.

In order to receive services through HOT, the individual must first be DMH eligible. Inpatient providers should therefore verify DMH eligibility for all homeless recipients immediately upon admission. If the recipient is DMH eligible, the provider should call HOT within 2 business days of admission. The provider should complete and forward a DMH eligibility packet for persons who are not already enrolled for DMH services within two business days of admission. Once a recipient is determined to be eligible to receive DMH services, the provider should contact HOT within two business days.

Massachusetts Housing and Shelter Alliance “The Road Home” Program
The Massachusetts Housing and Shelter Alliance (MHSA) will be implementing an Interactive Voice Response system designed to provide custom-tailored resources for homeless recipients. The system will identify appropriate, non-shelter, placements and dispositions. Additional support such as transportation, legal services, and specialized interventions will also be offered. All resource information will be faxed to the caller within several minutes of placing the call.

In order to access the “Road Home” system, providers must first register with MHSA and obtain a Personal Identification Number (PIN). This is a one-time procedure, which may require up to a 24-hour turn around before the PIN is issued. Providers are therefore encouraged to apply for their PIN number before they are presented with difficult discharge planning situations. MHSA is in the final stages of finalizing the Interactive Voice Response system. When the system is activated, the 888 number will be published.

To apply for a PIN, providers should contact John Kane at MHSA at (617) 367-6447, or E-Mail: John@MHSA.NET

Other Resources
A listing of alternatives to shelter discharges in the Boston, and Metro-Boston areas was offered in the April 16th training. These resources vary from Supported Housing for Homeless Persons with Substance Abuse, to respite beds available for Homeless Persons with psychiatric disorders. This list is enclosed at the end of this alert.

Sharing Resource Information

The Partnership encourages facilities treating homeless recipients to join in a collaborative effort with other providers and The Partnership to share knowledge of additional resources for homeless persons not listed in this alert.

REVIEW QUESTIONS

The April 16th training also presented several review questions implemented by The Partnership that will be asked on admission, concurrent review, and discharge of each homeless recipient utilizing hospital level of care.

These questions will evaluate the effectiveness of discharge planning procedures, and of providers' adherence to timely discharge planning. Data complied from these questions will also allow The Partnership to better understand the disposition needs of Homeless Persons.

The review questions are attached to this alert.

QUESTIONS

If you have questions concerning this alert, other initiatives for the Homeless, or wish to share information about additional resources for homeless persons, please contact Fred Furnari, Chair of The Partnership's Homeless Task Force at (617) 350-1922.

MBHP
Massachusetts Behavioral Health Partnership

HOMELESS PERFORMANCE STANDARD
DATA COLLECTION TOOL

The following questions have been incorporated into the Pre-authorization, Concurrent and Discharge review forms:

PRE-AUTHORIZATION REVIEW

45. Is the client homeless? Yes____ No____

CONCURRENT REVIEW

55. Is the client a homeless adult and admitted to a hospital in Regions I or V? Yes___No___

    If 'yes' answer questions 56, 57 & 58:

56. Did the Provider contact family, friends, the Triple 8#, or other agencies that assist with non-shelter placement of homeless recipients and document the specific resources in the chart?

    A. Made contacts: resource found
    B. Made contacts: no resource found
    C. No contacts made
    D. Pt refused consent to contact

57. If the pt is not a DMH client, was the DMH application for eligibility completed and forwarded within two business days of admission?

    Yes____ No____ Not Applicable ____

58. Was the Homeless Outreach Team contacted: (A) within two business days of admission if pt is a DMH client and a resident of Boston, Cambridge or Somerville or (B) within two business days of acceptance for DMH eligibility?

    Yes____ No____ Not Applicable ____

DISCHARGE REVIEW

68. Is the client homeless at the time of discharge?

    Yes ____ No ____ Unknown ____

70. Where will the client reside immediately upon discharge?

A. Alone/Home	F. DSS/DOE Rsi	K. Shelter
B. Family/Home	G. DPH Rsi	L. Unknown
C. Friends/Home	H. Jail/Court	M. Step Dn/Trn 24Hr Care
D. Foster Care	I. ½ Way/Grp Hme	N. Left AMA or AWOL
E. DMH/DMR Rsi	J. Medical/Nursing Hme	O. Other
		P. Pt Refused

DISCHARGE PLANNING RESOURCE LIST FOR HOMELESS INDIVIDUALS

Prepared by:

Sue Estes Shaw, Department of Mental Health
Tom Lorello, Tri City Mental Health Center

RESOURCE AREA: METRO BOSTON			
St. Alphonsus Respite Program 4 beds, 29 day respite	DMH Homeless Outreach Team	(617) 727-5000 x 137	Prior to referral, all clients must be determined DMH eligible through Metro Boston.
Lindemann Respite 6 beds, 60 day respite for Lindemann clients	Michelle Anzaldi	(617) 727-5500	Prior to referral, all clients must be determined DMH eligible through Metro Boston.
Cambridge Respite 4 beds for Cambridge DMH clients	Louise Marks	(617)354-8543	Prior to referral, all clients must be determined DMH eligible through Metro Boston.
Fenwood Inn 50 bed transitional program for Massachusetts Mental Health Center clients	Marie Cates	(617) 734-1300	Prior to referral, all clients must be determined DMH eligible through Metro Boston.
West End Transitional Program 30 bed program for 10 women and 20 men	DMH Homeless Outreach Team	(617) 727-5000 x 137	Prior to referral, all clients must be determined DMH eligible through Metro Boston.
Parker Street West 20 bed transitional program for women	DMH Homeless Outreach Team	(617) 727-5000 x 137	Prior to referral, all clients must be determined DMH eligible through Metro Boston.
Albany Street Lodge 20 bed transitional program for men and women	DMH Homeless Outreach Team	(617) 727-5000 x 137	Prior to referral, all clients must be determined DMH eligible through Metro Boston.
Bay View Inn Dual diagnosis transitional program for 25 men	DMH Homeless Outreach Team	(617) 727-5000 x 137	Prior to referral, all clients must be determined DMH eligible through Metro Boston.
Pelham Rest Home Stays limited to 30 days	Mike Galinas	(617) 527-5833	For Medicare clients awaiting further placement.
McInnes House Medical Respite		(617) 522-7080	
Boston Housing Authority		(617) 988-4000	

RESOURCE AREA: METRO-WEST			
RESOURCE NAME	**CONTACT / REFERRAL**	**TELEPHON E NUMBER**	**COMMENTS**
Low Income Housing 10-12 Maple St., Waltham	Leo Ledger	(781) 893-4155	The price range for a room is $110-150 per week.
Low Income Housing	Kelmark Associates	(781) 899-1480	Various price ranges available.
Southern Middlesex Opportunity Council HIV / AIDS Supported Housing	Irene Costello	(617) 482-8037	
Southern Middlesex Opportunity Council Substance Abuse Supported Housing	Darlene Asenco Beth Connally	(508)879-6691 (508) 620-2322	

Network Alert

The Partnership 150 Federal Street, 3rd Floor Boston, MA 02110 800-495-0086 Fax: 617-790-4133

ALERT # 67 MAY 9, 2000

TREATMENT IMPROVEMENT SERIES

SERIES #1:

DISCHARGE PLANNING FOR ADULTS WHO ARE HOMELESS

THE FOLLOWING INFORMATION SHOULD BE NOTED AND COMMUNICATED IMMEDIATELY TO YOUR PROGRAM DIRECTORS AND DISCHARGE PLANNERS

This alert serves to announce the initiation of Treatment Improvement Series #1. This Improvement Series is offered in response to, and in support of initiatives begun to increase awareness of and improve discharge planning for homeless members receiving care in acute settings (inpatient, detox, and crisis stabilization programs). The Partnership has developed the Treatment Improvement Series to ensure that the mental health and substance abuse treatment available through the Partnership's provider network is of the highest quality and optimally responsive to high risk members. The Improvement Series is designed to educate providers regarding improvement protocols, to articulate expectations regarding staff training, and to review treatment improvement monitoring systems.

Included in this alert is a descriptive overview of Improvement Series #1, (treatment improvement protocols designed to better focus the discharge planning process), a discussion of upcoming Partnership training, a description of follow up monitoring activities, and a discussion of other initiatives to improve discharge planning. The Partnership is working on a number of projects in collaboration with provider groups, homeless advocates and state agencies to increase the number of discharge resources available to homeless individuals being discharged from acute psychiatric care services and detox facilities. A summary of these initiatives is also included in this Alert.

> ***Treatment Improvement Series*** - *To ensure a comprehensive approach to behavioral health treatment for all of its members, the Partnership has developed Performance Specifications for each level of care in its provider network. To ensure compliance with Performance Specifications and to continuously improve the quality of care provided to our members, the Partnership has developed a Treatment Improvement Series to help providers fully comply with our performance expectations. The Treatment Improvement Series consists of three key components: 1) treatment improvement protocols; 2) treatment improvement training; and 3) treatment improvement monitoring.*

Improvement Series #1 Overview

For a variety of reasons, the number of individuals presenting at area shelters is increasing significantly, and the availability of suitable housing alternatives is decreasing. It is imperative that aggressive and comprehensive discharge planning occur for every individual who is homeless and being discharged from acute care settings, and that all potential avenues to secure placement or housing resources are exhausted. The Partnership reiterates in this alert its expectation that acute care providers follow exemplary discharge planning practices, and further reiterates its directive promulgated in Network Alert # 41 which strongly discourages the discharge of members to shelters. Additionally, in recognition of the special discharge challenges presented by members who are homeless, and in order to facilitate and improve discharge planning efforts, the Partnership offers protocols, guidelines, and information through this Alert.

Definition of Homelessness:

The Partnership's definition of homelessness is consistent with the Federal definition of Homelessness: Individuals aged 19 and over who lack regular, fixed and adequate nighttime residence, and who, on a temporary or permanent basis, have a primary residence, that is a shelter or similar facility, or who have no primary residence, and utilize public areas for sleep, shelter, and daily living activities.

> ***Treatment Improvement Protocols*** - *As part of its Treatment Improvement Series, the Partnership disseminates Treatment Improvement Protocols to provide clarification of previously issued Performance Specifications and to provide specific practice guidelines.*

Improvement Series #1, Protocols

The Partnership expects and directs its acute care providers to incorporate exemplary discharge planning practices into their routine discharge planning processes. The Partnership supports providers' compliance with its directives through the identification and promotion of exemplary discharge planning practices, through knowledge dissemination, systems and patient advocacy, and training. In order to underscore the importance of exemplary discharge planning in acute care settings, the Partnership establishes, through this Alert, the following policy and protocols.

1. Discharge Planning Process, Protocols

Appropriate discharge planning for individuals who are homeless requires aggressive and exhaustive efforts on the part of all treatment team members and discharge planners in particular. At a minimum, the following steps should be completed as a routine part of the discharge planning process for each member who is homeless (and documented in the member's medical record):

- Attempts to identify and contact family members and other support systems in the member's community
- Immediate notification of the DMH Homeless Outreach Team (HOT Team) for all individuals who are DMH clients
- A DMH referral of any patient who is likely to meet the criteria for DMH services
- Referral to the Partnership's Intensive Clinical Management program
- Initiate contact with The Road Home (see page 4)
- When an acute care treatment team has determined that a brief extended acute care or detox stay is necessary for the safe transition of a homeless patient to an appropriate discharge placement, the facility should formulate and present the request, with time parameters, to the Partnership for review and approval.
- Except in cases of documented competent refusal of alternative options by a patient, or exhaustion of all reasonable means to arrange for a non-shelter placement, a discharge to a homeless shelter or "the street" is considered a clinically inappropriate outcome of the discharge planning process. Under such circumstances, the discharging facility must ensure the availability of optimal post discharge support and clinical care. The facility must document in the medical record all efforts made to identify and offer alternative options and shall keep a record of all such discharges.

2. <u>Referral Process, Protocols</u>

a. DMH Referral. The provider should endeavor to complete and forward a DMH eligibility packet for persons who are not already enrolled for DMH services within two business days of admission. In the Metro Boston Area, once a patient is determined to be eligible to receive DMH services, the provider should immediately initiate a HOT Team referral as noted below.

- **DMH HOT Team Referral** ***(available to members in the Metro Boston Area)***. People who are homeless in the cities of Boston, Cambridge, and Somerville may be eligible to receive services through the DMH Homeless Outreach Team (HOT Team). The HOT Team assists homeless persons to find temporary and transitional housing. Additional services include case management and outreach to hospitalized individuals when appropriate. <u>In order to receive services through the HOT team, the individual must be DMH eligible (as determined by DMH). Inpatient providers should therefore verify DMH eligibility for all patients who are homeless immediately upon admission</u>. If the patient is DMH eligible, the provider should contact the HOT Team within 2 business days of admission

b. ICM Referral. Review of empirical literature on homelessness reveals that case management approaches which provide frequent service contact are a critical ingredient leading to positive housing and treatment retention outcomes. In recognition of these findings, the Partnership issues the following Policy & Protocol Directives:

- *Automatic ICM Eligibility:* <u>Members who are homeless and mentally ill and/or struggle with chemical dependency are automatically eligible for Intensive Clinical Management (ICM) services through The Partnership</u>.

- *Wrap Around Community Support Services:* The ICM program offers one point of contact at the Partnership and "wrap around" Community Support Program (CSP) services.
- *Acute Care Bridge Visits:* The Partnership and Community Support Program provide acute and routine bridge visits a) to facilitate timely access to community support services, b) to establish rapport with members identified for potential referral, and c) establish a point of initial contact for members who have accepted ICM/CSP services. The CSP worker helps the member to identify those behavioral health services which will be most helpful.

Mobile Outreach Services: The Partnership has expanded its Community Support Program to provide targeted community support for members who are homeless. Mobile outreach services, including Mobile Psychopharmacology Services, are available to members who are homeless through the Partnership's ICM program.

ICM services vary based on the need of the member and available regional resources, but they always include a comprehensive service plan with care management provided on site at the Partnership (see page 8 for details on the role of the CSP).

c. **Health Care for the Homeless Pilot Project Referral.** In a study of mortality and homelessness conducted in Boston last year by *Health Care for the Homeless (HCH)*, common characteristics of homeless individuals who died on the streets of Boston were identified. The study highlights risk factors that should be considered prior to the discharge of any homeless individual. The risk factors, identified in the study, are:
   Tri-morbidity: medical problems, substance abuse and severe and persistent mental illness
   Three or more emergency room visits or hospital admissions in the previous three months
   Age over 60 years
   HIV/AIDS
   Cirrhosis, end stage liver disease, or renal failure
   History of frostbite, hypothermia, or immersion foot

The Partnership joins Healthcare for the Homeless in recognizing the importance of communicating these risk factors to providers throughout the Commonwealth. Additionally, The Partnership strongly encourages acute care psychiatric and detox providers to notify HCH when encountering high-risk patients who are homeless in the Boston Region. <u>Patients who are homeless and who present with one or more risk factors (without regard to health care insurance) may be appropriate for a pilot program offered through HCH. Call HCH at (781) 221-6565, and inquire about case management services available through the pilot program for these patients.</u>

3. <u>Discharge Planning Resources</u>

Through a collaborative effort with stakeholders and advocates, the Partnership has developed a Homeless Services Resource List for its network providers. Relationship building with these resource providers is considered essential and is a Partnership expectation of each Network acute care facility. The Partnership also expects that inpatient psychiatric and detox providers will pursue and exhaust other resources when planning discharges for patients who are homeless. In collaboration with the homeless advocacy community, the Partnership has also identified strategies and resources to facilitate appropriate discharge dispositions for members. To aid providers in the discharge planning process the following resources are available to network providers:

- **Massachusetts Housing and Shelter Alliance "The Road Home" Program.** The Massachusetts Housing and Shelter Alliance (MHSA), in collaboration with the Partnership, and EOHHS agencies, has implemented an interactive voice response system designed to identify custom-tailored resources for individuals who are homeless (appropriate, non-shelter placements and dispositions). Additional support such as transportation, legal services, and specialized interventions are also offered. All resource information will be faxed to the caller within several minutes of placing the call.
- *"The Road Home" Program Registration*: In order to access the "Road Home" system, providers must first register with MHSA and obtain a Personal Identification Number (PIN). This is a one-time procedure which may require a 24-hour turn around before the PIN is issued. Providers are therefore encouraged to apply for a PIN number before they are presented with difficult discharge planning situations. MHSA is in the final stages of finalizing this interactive voice response system.
- *Contacting MHSA*: When the system is activated, the 888 number will be published. To apply for a PIN, providers should contact John Kane at MHSA at (617) 367-6447, or e-mail: John@MHSA.Net.

- **Partnership on Site Support for Discharge Planning (available to Metro Boston Facilities)** The Partnership, in collaboration with the Department of Mental Health, has developed the capacity to assign DMH Homeless Outreach Team staff to high volume acute care facilities to assist discharge planners, on site, and better coordinate discharge planning.

Treatment Improvement Trainings - *This Treatment Improvement Protocol and other references are the basis for the design of our training program for practitioners in the field. Training is critical given the challenges faced by discharge planners and the varying levels of expertise of the staff who will utilize the protocol. It is expected that staff across the system will utilize established protocols in a standardized fashion to insure improved performance within the system. Training will facilitate and enable staff to do so, and help to ensure enhanced levels of clinical capability. In the context of the training, the Partnership will develop standardized definitions of terms and to ensure consistency, will work with stakeholders to develop a set of measurable, objective criteria for selecting treatment and service options.*

Improvement Series #1 Training.

Series #1 training will provide additional education to acute care providers on the importance of comprehensive discharge planning for our members who are homeless. Beginning January 18, 2000, the Partnership began conducting training for discharge planners in key high volume psychiatric facilities. This training emphasizes knowledge of the current homeless population, availability of existing resources, essential steps in discharge planning for members who are homeless, and planned initiatives to improve discharge planning. While targeted facilities will participate in the initial round of training, eventually, this training opportunity will be available to all acute care providers. Please contact your Partnership Regional Manager for additional information.

Treatment Improvement Monitoring - *Ensuring implementation of Treatment Improvement Protocols is an important aspect of the Partnership's clinical care management and network management strategies and is incorporated into the Partnership's Outlier Management Program. Quality assurance is critical to program efficacy and is encouraged at the provider level.*

Improvement Series #1 Monitoring.

The Partnership will include compliance with this protocol as component of a provider's overall performance review within the Utilization Outlier Management Program. Establishing tracking mechanisms for monitoring provider performance relative to identified discharge planning strategies is an important aspect of this Improvement Series. The Partnership will monitor compliance with these protocols through chart audits, on site reviews by network specialists, and through care management reviews. Chart audits will be conducted to ensure that adherence to these exemplary practices for discharge planning of members who are homeless is documented in each medical record. In addition, the Partnership has incorporated a series of questions into its pre-authorization, concurrent review and discharge review processes to ensure provider compliance. The Partnership collects data on the number of our members who are homeless and data on actual dispositions of these homeless members. The Partnership will use this information in collaboration with providers to further facilitate exemplary discharge planning.

The Partnership expects and encourages providers to self-monitor their compliance with these protocols through:

- Quality improvement initiatives with a focus on clear internal policies, accountability, and accurate record keeping,
- Chart audits designed to measure performance,
- Consistent supervision with attention to the clinical and administrative aspects of the discharge planning process; and training where information is shared openly among staff, and
- Other monitoring mechanisms tailored to individual facility challenges.

Other Discharge Planning Improvement Initiatives

1. Performance Standards

Discharge Planning Improvement Initiative: For FY '99, the Division of Medical Assistance (DMA) established a Partnership Contract Performance Standard that focused on improving discharge planning for members who are homeless in the Boston and Greater Boston Regions. This initiative resulted in the identification of discharge resources, the beginning of a tracking system at the Partnership to better determine the needs of homeless members, and a collaborative training with homeless advocates and select network acute care facilities. This year, DMA has expanded the Discharge Planning initiative to the Worcester and Springfield regions. Inpatient facilities in these regions have been added to data collection protocols, will participate in Partnership discharge planning training sessions and will be added to the Partnership's care and network management protocols for monitoring discharge planning of members who are homeless.

Internet Web Site Initiative: DMA has also established a Contract Performance Standard that requires the Partnership to develop a web site, available via the Internet, which lists available services for people who are homeless. Once established, the web site will allow providers to access on-line referral and service information (e.g. housing resources, behavioral health, healthcare, self-help and social services). The web site information is being developed in collaboration with the homeless advocacy and service community.

2. Program for Assertive Community Treatment (PACT)

In collaboration with the Department of Mental Health, a pilot program to initiate PACT teams in Worcester, through Community Health Link commenced in January, 2000, and in Lowell, through TriCity Mental Health, beginning March, 2000. The PACT model is conceptualized as a “hospital without walls”. The model, which has a demonstrated effectiveness in other major cities, provides the opportunity for intensive clinical assessment and intervention for clients who have a serious mental illness and are often treatment resistant. Some of the individuals who have been successfully treated through the PACT model are also homeless. PACT teams provide outreach, tracking and housing coordination and assistance.

Through this Improvement Series, the Partnership underscores the importance of exemplary discharge planning practices by all Network providers. The Partnership is committed to working with the provider community, homeless advocates, agencies, and our membership to ensure appropriate accessible behavioral health services for members who are homeless.

Role of Community Support Program (CSP)

The role of the CSP is to facilitate treatment access, coordinate, negotiate, and ensure the appropriateness of services and resources that are necessary to meet consumer needs. The CSP is a key intervention strategy for improving access to the service system by members who are homeless. Given that many people who are homeless may be distrustful and suspicious of service providers (and value their autonomy), one of the CSP's primary tasks is to engage people who are homeless and develop and nurture trust and a working alliance. The Intensive Case Management program and CSP services are designed to assist members to overcome their distrust of service providers, coordinate needed treatment and support services, and guide members along the treatment continuum. The Partnership defines eight (8) specific functions of the CSP as follows:

- **Discharge Planning:** help members to transition from acute care settings to community-based services.
- **Outreach:** efforts to engage members in services.
- **Assessment:** to determine the member's current and potential strengths, weaknesses and needs.
- **Service Planning & Linkage:** to develop specific, comprehensive, individualized treatment and service plans; to refer and link members to necessary long-term services and supports, including primary health care services, mental health, substance abuse, and social services.
- **Monitoring & Crisis Intervention:** to conduct ongoing evaluation of client progress and needs, modify the treatment plan as necessary, and assist clients in crisis through direct interventions and mobilizing needed supports and services.
- **Client Advocacy:** to intercede on behalf of a specific client or group of clients to ensure access to appropriate services.
- **Direct Service:** providing emotional and practical support during critical periods of transition to new services.
- **Resource Identification:** identifying and arranging access to services or resources to address the needs of clients.

Review of research literature reveals that clients with shorter lengths of time homeless, clients with fewer psychotic symptoms, women, and clients without substance abuse problems tend to have better outcomes when receiving ICM/CSP type care management services. To improve outcomes for clients who have longer lengths of time being homeless, clients with more psychotic symptoms, men, and clients with co-occurring substance abuse disorders the Partnership will design intervention strategies and training to assist CSP providers in achieving better outcomes for all homeless population cohorts.

For information on the ICM program and to refer a member for Community Support Program Services, contact the Regional Clinical Supervisor serving your region:

Greater Boston and Northeast Area	Bernita Krueger, LICSW	617 350 1925
Boston and Southeast	Rodney Dismukes, Ph.D.	617 350 1923
Central Region	Mike Zwalsky, Ed.D.	508 890 6404
Western Region	Meredith Taylor, Ph.D.	413 858 1808

Acute Care Discharge Planning Process

Checklist

In an effort to ensure that every effort has been made to access housing resources for homeless members, the Partnership requires documentation in the medical record for each homeless member, which documents the completion of the discharge planning process. This checklist outlines the areas to address in the documentation.

- ❑ Is there documentation that supports efforts made to contact the member's family and community supports?

- ❑ Immediate notification to the DMH Homeless Outreach Team (HOT) for all members who are DMH clients:
- Is the member DMH eligible? If so, contact the HOT Team within two business days.
- If the member is not a DMH consumer, is there evidence that a DMH eligibility packet was completed and sent to DMH within two days of admission?

- ❑ Intensive Clinical Management (ICM) referral to the Partnership
- Was the member considered for an ICM referral?
- Was an application for ICM services completed and faxed to the Partnership?

- ❑ Are efforts documented to access those resources listed in the Partnership's Homeless Services Resource List?
- Is there documentation of each resource contacted?
- Is there documentation of the result of each contact?

- ❑ Was additional time in an acute care setting negotiated with the Partnership to ensure a transition to an appropriate discharge setting?

- ❑ Is the member a veteran?
- If so, has the Veterans Administration been contacted for potential resources?

- ❑ Is the member's PCC aware of any current medical conditions which require treatment?

- ❑ Does the member have a chronic medical condition?
- If so, has a referral to a nursing home or extended care facility been considered?

Future Partnership chart audits will measure compliance with this Discharge Planning Process

Network Alert

The Partnership 150 Federal Street, 3rd Floor Boston, MA 02110 800-495-0086 Fax: 617-790-4133

ALERT # 71 JUNE 30, 2000

Performance Standard #9: Internet Technology and Resources for Services to Homeless Members

www.masshomelesshealth.org

THE FOLLOWING INFORMATION SHOULD BE NOTED AND COMMUNICATED IMMEDIATELY TO YOUR PROGRAM DIRECTORS AND DISCHARGE PLANNERS

This alert serves to announce the launch of www.masshomelesshealth.org, an internet-based compilation of resources for homeless individuals. The Massachusetts Behavioral Health Partnership has collaborated with the homeless advocacy and health care provider community to develop and construct a web site that contains aftercare planning best practices and referral information for both behavioral health and physical health resources, specifically for providers of services to homeless members.

Included in this alert is a descriptive overview of the web site, including an overview of content and how to access it. The target audience of this web site are providers of services to homeless members. Homeless members are those who lack regular, fixed, and adequate nighttime residence, and who, on a temporary or permanent basis, have a primary residence that is a shelter or similar facility, or who have no primary residence, and utilize public areas for sleep, shelter, and daily living activities. Members are individuals who are enrolled in MassHealth Standard in the Persons with Disabilities rating category, MassHealth Basic, and/or DMH Consumers.

Access to www.masshomelesshealth.org

The web site can be accessed from any computer with an active connection to the internet. Computers with active connections to the internet, beyond those located in treatment facilities, are available at almost every public library in the Commonwealth of Massachusetts.

Users need only launch a web browser application and enter the URL/web page address: **www.masshomelesshealth.org**.

Information Contained in the Site

Information contained in the site can be accessed in multiple ways. Information can be viewed for specific resources (e.g.: "food," "clothing," "shelter"), as well as for *all* resources in a given area. Information can be viewed for an entire Region, as well as for a specific City or Town. Information from larger, "umbrella" organizations are also listed and available from www.masshomelesshealth.org by clicking on "Resource Links" at the bottom of any page.